LABOR AND INDUSTRIES
WORKERS' COMPENSATION FRAUD REPORT

Fiscal Year 2003

Contents

EXECUTIVE SUMMARY

This is the department's ninth annual fraud report. It provides a comprehensive report on workers' compensation fraud in Washington as mandated by RCW 43.22.331.

The department pursues three categories of fraud. Examples of these are as follows:

- **Employer fraud** is knowingly misclassifying employees in lower-cost rate classifications, underreporting worker hours, or failing to pay required premiums.
- **Worker fraud** is filing claims for benefits when the injury occurred outside of work; misrepresenting the level of wages or marital status in order to receive more benefits; intentionally misrepresenting physical limitations; engaging in work activities while receiving disability benefits; and accepting benefits intended for a beneficiary who is deceased.
- **Provider fraud** is billing the department for services that were not provided or submitting bills using codes and practices (for instance, unbundling) that generate overpayment.

Fraud can potentially be identified in a number of different ways:

- During audits of employer or provider records.
- Through tips from customers, staff and other agencies.
- By cross matching data with other government organizations.
- Through a publicized fraud hotline.

Several areas of the department work to detect and expose fraud and abuse of the workers' compensation system. Field audit activity identifies employers who underpay or evade premiums for workers. The Investigations Unit identifies workers and beneficiaries who obtain benefits to which they are not entitled. The Provider Fraud Unit identifies health care providers who have billed for illegitimate or exaggerated services.

In this report, costs will be presented in two ways. One will reflect costs in a manner consistent with previous reports based on the average cost per hour to investigate cases resulting in the issuance of administrative fraud orders or overpayments. Activity level costs will also be presented in order to be consistent with new budget development requirements.

The estimated costs of activities resulting in the issuance of fraud orders and overpayments, using the same method as in the department's previous annual fraud reports, was $4.8 million. The operating cost at the activity level was $6.5 million.

The total amount assessed during FY 2003 through administrative fraud orders, settlements, assessments, cost avoidance and court orders was $19.4 million.

During FY04 the department will be strengthening its efforts to control fraud in several ways:

- Proposing legislation that addresses areas that have shown to be problematic in addressing worker, provider and employer fraud.
- Stepping up our efforts to raise awareness about fraud in industrial insurance, including publicizing those cases with significant findings.
- Expanding our efforts in the construction industry as a whole – with a goal to increase collections resulting from audit and other tax discovery methods by $1.8 million.
- Responding to labor, business and local law enforcement concerns about illegal operations in the brush picking industry.
- Reallocating resources and adding staff to more effectively detect and pursue fraud and abuse of the workers' compensation system.

The department is committed to reducing fraud and abuse. The department will continue to explore discovery methods to disclose additional fraudulent activity.

BACKGROUND

This is the ninth fraud report mandated by RCW 43.22.331, which provides, "The department shall annually compile a comprehensive report on workers' compensation fraud in Washington. The report shall include the department's activities related to the prevention, detection, and prosecution of worker, employer, and provider fraud and the cost of such activities, as well as the actual and estimated cost savings of such activities. The report shall be submitted to the appropriate committees of the legislature prior to the start of the legislative session in January."

While the cost of uncovering fraudulent activity is easily identified, total cost-avoidance benefits to the system are not. The deterrent effect of media coverage and exposure on contemplated fraud or abuse cannot be measured.

Several areas of Labor and Industries work to expose fraud and abuse of the workers' compensation system. Field audit activity identifies employers who underpay or evade premiums for their workers. The Investigations Unit identifies workers and beneficiaries who obtain benefits to which they are not entitled. The Provider Fraud Unit identifies health care providers who have billed for illegitimate or exaggerated services

Proving fraud in court is difficult because to get a conviction requires the showing of intent. Nevertheless, in our attempt to uncover wrongdoing, we pursue three categories of fraud discussed in this report:

- *Employer Fraud*
- *Worker Fraud*
- *Provider Fraud*

In this report, assessments and costs will be presented in two ways. One will reflect costs in a manner consistent with previous reports that were based on the average cost per hour to investigate cases resulting in the issuance of administrative fraud orders or overpayments. The other will reflect the costs at the activity level in order to be consistent with the new budget process.

Employer Fraud

Employer fraud involves employers who knowingly misclassify employees in lower-cost rate classifications, underreport worker hours or fail to pay required premiums.

The department is continually trying to improve the process by which it identifies and investigates employers who intentionally defraud the department. We have established criteria to clearly identify what constitutes employer abuse of the industrial insurance system. The criteria include:

- Unregistered employers
- Employers who intentionally falsify their records
- Employers who continue to hire workers after having their certificate of workers' compensation insurance revoked
- Employers who abuse independent contractor rules to avoid paying premiums, and
- Employers who demonstrate a pattern of closing one business and opening another in order to avoid workers' compensation insurance premiums.

The department works closely with other state agencies and the Internal Revenue Service to crosscheck employment records and identify employers who abuse the system. We also work with the Office of Attorney General to impose the maximum appropriate civil penalties on those employers demonstrating the most egregious misconduct. Cases that rise to the criminal level are referred for prosecution when appropriate.

Field Audit

The Field Audit Program plays a large role in identifying and targeting fraud. One of the program's primary duties is verifying employers' premium reporting and identifying under reporting. The department's staff conduct field audits by evaluating employers' reporting histories and conducting reviews of employer records in the field. If there is an indication of fraud, the audit is referred for an investigation.

Since premiums are determined by comparative risk analysis, businesses with workers exposed to greater risk of injury, such as logging or construction, pay higher premiums. Some employers intentionally misreport employee hours in lower-risk classifications than the work they are actually performing in order to pay lower premiums to the department. Some employers do not register in order to avoid paying premiums. Legitimate businesses complain that these underground economy employers have an unfair competitive advantage over those who do not abuse the system and pay premiums.

The department's 43 field auditors routinely coordinate with other state agencies to investigate cases of potential fraud. During fiscal year 2003 (FY03), the Field Audit Program conducted 3,289 compliance audits on employers that resulted in the assessment of $9.3 million in additional premiums. The interaction between the auditors and the public brought to light many instances of potential fraud.

In addition to ongoing activities, the department implemented two initiatives targeted at specific industries:

- ***Residential Wood Framing:*** The department assessed $1,848,513 in additional premiums in this industry and established accounts for 229 previously unregistered framing employers. For the second year, the department continued its program to bring all framers into compliance by:

  - Increasing the number of employers in the industry who report framing work.
  - Identifying under reporting of premiums and hours. (Of the 1,027 framing audits conducted in FY 2003, 505 were found to be out of compliance.)

  These efforts resulted in the highest number of accounts reporting framing hours worked since 1995 in the third and fourth quarters of the fiscal year. This increase occurred in spite of the fact that the overall number of framers with L&I accounts decreased.

- ***Pursuing collection from unregistered employers:*** During FY03, the department collected $3,193,069 from unregistered employers, exceeding the goal the department set by 28%.

  Washington has a significant number of employers who are not properly registered and don't pay workers' compensation premiums or state taxes. They can "underbid" their competitors who pay premiums, putting the honest employer at a competitive disadvantage. These employers are also likely to be out of compliance with other laws and rules aimed at consumer protection, worker safety and protection from economic hardship.

Year	**Operating Costs**	**Assessments**	**Recoveries**	**Return on Investment** (Assessments to Costs)
FY 2003	$3.3 million *	$9.3 million	$3.2 million	3 to1
FY 2002	$3.4 million	$8 million	Not Available **	2 to 1
FY 2001	$3.4 million	$9.4 million	Not Available **	3 to 1

* *Operating costs are the total expenditures related to the program, which includes compliance and educational audits.*

** *Data not collected.*

Worker Fraud

Worker fraud occurs when an employee receives workers compensation benefits by fraudulent means. Worker fraud usually receives more public attention because, when detected, it tends to get more coverage by the media. The Investigations Unit receives fraud referrals directly from the claims adjudication staff. The department often receives allegations of worker fraud through anonymously provided information. This information is pursued by the department's Investigations Unit.

The department's investigators investigate worker fraud in the receipt of time loss (temporary total disability) and pension (permanent total disability) cases. Fraud can involve the injured worker or others attempting to collect benefits illegally under the claim.

Allegations of inappropriate activity and database cross-matches with other governmental agencies drive the majority of fraud investigation assignments.

A breakdown of discovery sources, resulting in fraud orders during FY03 is as follows:

Discovery Source	FY02	FY03
Anonymous/Tips	16%	17%
Claims Managers	9%	13%
Employers	5%	19%
Employment Security/Department of Corrections	58%	41%
Other Internal	5%	0%
Internet	1%	1%
Vocational Counselors	3%	0%
Attending Physicians	3%	1%
State Auditor	0%	8%
TOTAL	100%	100%

The department begins a fraud investigation when an activity check reveals that a claimant may be receiving benefits by fraudulent means. Once enough information has been gathered to make a determination that fraud is involved, an administrative fraud order is issued by the department's fraud adjudicator, demanding repayment of time-loss, pension, medical or vocational benefits and a penalty of up to 50 percent of the total amount of the benefits received fraudulently. Criminal charges are sought in the most egregious cases and are pursued through individual county prosecutors. If the department fraud adjudicator and assistant attorney general determine that information exists that the worker was abusing the system but is not sufficient to prove fraud, the adjudicator will work to terminate benefits and issue an overpayment order.

For both administrative fraud orders and overpayment orders, the department estimates cost avoidance or benefits that are not paid out as a result of the termination of benefits, on a case-by-case basis. This cost avoidance estimate is based on the amount that would have been paid on the claim in time-loss compensation benefits over the next year or the expected life of a pension. The combined overpayments, penalties, and cost avoidance for FY03 for worker fraud was $5.2 million. Collections are significantly less because they are impacted by settlement and plea agreements and the claimant's inability to repay the debt.

Action	Number	Dollars	Cost Avoidance
Administrative Fraud Orders	153	$2.4 million	$1.9 million
Overpayments	23	$59,000	$ 834,400
Total	176	$2.5 million	$2.7 million

We have expanded the number of government agencies with whom we cross-reference information. In FY03, we entered into a data sharing agreement with the Department of Social and Health Services, which allows us to cross-match newly hired employees against workers receiving time-loss benefits.

Cross-referencing with the Employment Security Department continues to identify potential fraudulent activity. We also cross-reference with the Social Security Administration to detect those receiving workers' compensation pensions in the name of deceased persons. In FY03, the department narrowed the search parameters in response to a finding by the State Auditor to better identify deceased workers who were receiving permanent total disability or survivor pensions. The department also established a new cross-referencing method with the Department of Corrections and obtained access to the national criminal database. This change will allow the department to discover information on injured workers incarcerated both in Washington and in other states.

Some cases result in criminal prosecution when deemed appropriate by the county prosecuting attorney with jurisdiction over the case. If the county prosecutor does not take the case, and we believe there is a reasonable chance for conviction, we have the option of working through the Thurston County Prosecutor.

Once a fraud adjudicator issues an administrative fraud order, that order may be appealed to the Board of Industrial Insurance Appeals and subsequently to Superior Court and the appellate courts. If the order is affirmed and becomes final and binding, it is forwarded to the department's Collections Section to pursue recovery.

Program Costs and Assessments

The operating costs shown below for Investigations is calculated in the same manner as costs captured in previous Fraud Reports. These costs reflect only those costs associated with the investigation of 153 cases resulting in the issuance of an administrative fraud order and 23 cases in which an overpayment was assessed.

Operating Costs	Overpayments and Penalties	Cost Avoidance	Fraud Recoveries	Return on Investment
$292,578	$2.5 million	$2.7 million	$580,700	18 to 1

The operating costs shown below for Investigations is calculated in accordance with new budget development guidelines on an activity level basis. These costs reflect the total program budget of $2.3 million, less $317, 602 in salaries and benefits for 6 FTEs dedicated to the investigation of Industrial Insurance Discrimination.

Operating Costs	Overpayments and Penalties	Cost Avoidance	Fraud Recoveries	Return on Investment
$2 million	$2.5 million	$2.7 million	$580,700	3 to 1

Provider Fraud

Provider fraud involves billing for services that were never provided or submitting bills using codes and practices (for example, unbundling) that generate overpayments. This type of fraud is often the most difficult for the department to detect.

Auditors in the Vocational and Health Care Provider Review and Education Unit investigate complaints and conduct audits of vocational and health care providers to ensure compliance with department laws, rules, policies and the medical aid fee schedules. Department Occupational Nurse Consultants also coordinate with the Department of Health's professional disciplinary boards on issues of integrity and quality of care, and take appropriate actions against a provider's ability to treat injured workers based on department findings or disciplinary board actions.

The Unit had one medical auditor for FY 03 and another auditor in training for four months. The medical auditors rely primarily on referrals from staff and citizens to uncover leads. When reports of questionable billing practices are received, they conduct an audit or prepayment review in cases where abuse of the system likely exists. Medical

auditors assessed $442,157 in overpayments and recovered $60,080 from eight providers. They revoked the provider numbers of two providers.

The vocational auditors monitor the work of vocational providers who provide services to Washington injured workers covered. Vocational auditors issued 33 orders as the result of audits and investigations. These orders resulted in overpayment assessments of $54,793.

Activity	**Operating Costs**	**Assessments**	**Recoveries**	**Return on Investment** (Assessments to Cost)
Medical	$ 75,000	$442,250	$ 60,000	
Vocational	$222,000	$ 54,750	$ 54,750	
Total	$297,000*	$497,000	$114,750 **	2 to 1

The Unit has approximately $1,027,767 in receivables due the department as a result of prior year audits. Although the Unit uses collection agencies and other means to recover funds owed the department, the lack of statutory authority to place a lien on a provider's property limits our ability to recover these funds.

Provider Fraud

The Provider Fraud program is comprised of auditors and investigators with legal representation provided by assistant attorneys general and county prosecuting attorneys. The staff evaluates complaints of fraud and conducts audits or investigations and determines what action, if any, will be taken based on the results of the investigation and audits.

For six months during this reporting period, the Provider Fraud Program had only one investigator and one auditor. A second auditor was added in January 2003. During this period, staff investigated or conducted audits of 34 new referrals, and closed 46 investigations.

In the table below, assessments are the identified loss of over $1 million plus the calculated penalties of $2.9 million. Cost avoidance is calculated on a case-by-case basis by reviewing the provider's historical billing practices and estimating what the loss would be over the next year if the questioned/illegal activity had not been stopped.

Operating Costs	**Assessments**	**Cost Avoidance**	**Recoveries**	**Return on Investment**
$645,000	$3.9 million	$470,500	$12,700	7 to 1

* *Operating costs are only for those personnel who were dedicated to conducting medical and vocational audits.*

** *Recoveries include both current year and prior year assessments.*

Next Year

In the department's public hearings on the proposed 2004 industrial insurance rate increase, employers made it clear that they want the department to more aggressively pursue abuse of the system. In FY 2004, we are taking a number of actions in response.

- The department will propose legislation that addresses areas that have been problematic in addressing worker, provider and employer fraud.

- The department will reallocate resources and add staff to more effectively detect and pursue fraud and abuse of the workers' compensation system.

- The department will expand its efforts with the construction industry to increase dollars collected as a result of our audit and other tax discovery efforts.

- The department will continue to focus on the specialty forest product industry and our obligations under the Farm Labor Contractor Act in response to labor, business and local law enforcement concerns about the brush-picking industry.

- The department is stepping up efforts to educate the public on types of abuses that exist in the workers compensation system in Washington State. Toward this end, we expect to increase our activities in the following areas:
  - Publicize significant cases in which fraud is found.
  - Enhance our website with information for the public about fraud and how to report it.
  - Evaluate new technologies to assist in targeting any potential fraud against the system.

Conclusion

The department is committed to protecting the integrity of the Washington workers compensation system by deterring, detecting and pursuing fraud and abuse. Since the public hearings concerning the 2004 rate increase, the department has placed a renewed emphasis on fraud and abuse of the system, and will make additional resources available to the effort while continuing to improve our existing methods.

Any questions regarding this report should be directed to:

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